



Delta Dental Plan of New Jersey

Mail to:  
P.O. Box 23700  
Newark, NJ 07189  
(973) 285-4144

Eight Digit Group Number

DeltaPremier

4230

(To be completed by employer)

- ☐ 0001 – Town  
☐ 0002 – Police  
☐ 0003 – Library

## DENTAL ENROLLMENT FORM

Name of Employer

Town of Darien

Effective Date of Coverage

### GENERAL INFORMATION - THIS SECTION MUST BE COMPLETED - PLEASE PRINT CLEARLY

|                    |                        |          |                                                                                                             |                                                                                                                                                                                                         |                                                              |
|--------------------|------------------------|----------|-------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|
| Name (Last)        | (First)                | (Middle) | Date of Birth                                                                                               | Social Security Number                                                                                                                                                                                  |                                                              |
|                    |                        |          | ____/____/____                                                                                              | ____-____-____                                                                                                                                                                                          |                                                              |
| Street Address     |                        |          | City, State, Zip                                                                                            |                                                                                                                                                                                                         | County                                                       |
| Date of Employment |                        |          | Type of Coverage                                                                                            | Marital Status                                                                                                                                                                                          | Home Telephone                                               |
| ____/____/____     |                        |          | <input type="checkbox"/> Single<br><input type="checkbox"/> Husband/Wife<br><input type="checkbox"/> Family | <input type="checkbox"/> Parent/Child<br><input type="checkbox"/> Parent/Children<br><input type="checkbox"/> Single<br><input type="checkbox"/> Married<br><input type="checkbox"/> Divorced/Separated | ( )                                                          |
| Enrollment         | First Name - Last Name |          | Social Security Number                                                                                      |                                                                                                                                                                                                         | Date of Birth                                                |
| Subscriber         |                        |          | ____-____-____                                                                                              |                                                                                                                                                                                                         | / /                                                          |
| Spouse*            |                        |          |                                                                                                             |                                                                                                                                                                                                         | / /                                                          |
| Dependent          |                        |          |                                                                                                             |                                                                                                                                                                                                         | / / <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependent          |                        |          |                                                                                                             |                                                                                                                                                                                                         | / / <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependent          |                        |          |                                                                                                             |                                                                                                                                                                                                         | / / <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Dependent          |                        |          |                                                                                                             |                                                                                                                                                                                                         | / / <input type="checkbox"/> Yes <input type="checkbox"/> No |

\* If spouse has other dental coverage, please list name and address of employer and other carrier:

I hereby represent that all information furnished is true and complete to the best of my knowledge and authorize my employer to make any required deduction from my wages.

Subscriber Signature

Date

Delta Use Only

Entered

Operator #